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ABSTRACT

Designed as part of a 40-hour course on adult residential care homes (ARCH's), this lesson plan was developed to explain the importance of and correct procedures for charting (i.e., keeping a written record of observations and care of ARCH residents). The objectives of the 50-minute lesson are to enable students to: (1) list reasons why the charting of residents' behavior and client care is important in ARCH functions; (2) describe the Problem Oriented Recording System; (3) explain the SOAP (Subjective Objective Assessment Plan) format for recording client progress; and (4) demonstrate the charting technique for a given situation. The lesson plan includes information on the course for which the lesson was designed; equipment and audiovisual aids needed; requirements for student materials; lesson objectives; bibliographic references; and special remarks for the instructor. Next, a step-by-step outline of the instructor's presentation is provided in a format indicating the length of time and the equipment or other aids necessary for each step of the lesson. Handouts and flip chart and transparency masters are included. (PAA)

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REPORTING AND CHARTING RESIDENTS' BEHAVIORS AND CARE IN AN ADULT RESIDENTIAL CARE HOME

Adult Residential Care Home 12,
Lesson Plan No. 2

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LESSON PLAN

LESSON PLAN NO.	INSTITUTION / AGENCY:	PAGE 1 OF 27 PAGES
2	Leeward Community College	

COURSE OF INSTRUCTION AND COURSE NUMBER:	TOTAL HOURS:	LESSON TITLE:
Adult Residential Care Home 12 (ARCH 12)	40 Hours	Reporting and Charting Residents' Behaviors and Care in an Adult Residential Care Home

DAY AND DATE OF INSTRUCTION:	HOURS	PLACE:
Thursday, November 6, 1986	5:00 - 5:50 p.m. (50 min.)	University of Hawaii-Manoa, Room 112

NO. OF STUDENTS:	REHEARSAL:	INSTRUCTOR AND ASSISTANTS:	STUDENT MATERIALS AND DRESS:
20	October 27, 1986 UH-Manoa Keller Hall #204	Terry Basuel	Notebook, pens and pencils Casual clothing

REFERENCES:

See page 2.

EQUIPMENT AND AUDIO-VISUAL AIDS:

See page 3.

OBJECTIVES:

See page 5.

SPECIAL REMARKS:

Students have previous knowledge of basic medical terminology.

Class open only to Care Home Administrators who meet the current qualifications of: High school or better; Nurse Aide experience of at least 1 year; Medical Assistants at least 1 year experience; Nursing experience at least 1 year in U.S.

PRESENTATION

OUTLINE OF INSTRUCTION	TIME	METHODS OF INSTRUCTION AND AIDS

References:

Allport, Gordon and Postman, Leo. The Process & Effects of Mass Communication. Urbana, Illinois. University of Illinois Press, 1960, pp. 141-155.

Metge, Joan and Kinlock, Patricia. Talking Past Each Other: Problems of Cross Cultural Communication. Wellington, New Zealand. Victoria University Press, 1984, pp. 7-59.

Ross, Raymond S. and Rossmark, G. Relating and Interacting. Englewood Cliffs, N.J. Prentice Hall, 1982, pp. 220-225.

Solomon, Douglas and Maccoby, Nathan. Behavioral Health: A Handbook of Health Enhancement and Disease Prevention. Silver Springs, MD. John Wiley & Sons, 1984, pp. 209-221.

Wood, Lucille A. and Rambo, Beverly J. Nursing Skills for Allied Health Services. Philadelphia, PA. W.B. Saunders Company, 1977, pp. 361-386.

PRESENTATION

OUTLINE OF INSTRUCTION	TIME	METHODS OF INSTRUCTION AND AIDS
Equipment and Audio-visual Aids: 1. Handouts: Handout #1 Class objectives #2 Progress Notes Form 2. Overhead Transparency: OH #1 Client Picture Eating Breakfast at noon. 3. Flip Charts and Stand 4. Flip Chart # 1 Objectives # 2 "SOAP" Blank form # 3 "SOAP" Explanation # 4 Diabetic Client Charting Example # 5 Psychiatric Disorder Client Charting Example # 6 2:30 p.m. Entry " " " # 7 2:40 p.m. Entry " " " # 8 4:00 p.m. Entry " " " # 9 "SOAP" Format #10 "SOAP" Practice Charting In-Class 5. Chalk, Multi-colors 6. Overhead Projector 7. Screen (Measurement: 5'x5') 8. Marking Pens, Multi-colors 9. Pointer		

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OUTLINE OF INSTRUCTION	TIME	METHODS OF INSTRUCTION AND AIDS
I. INTRODUCTION		
A. The purpose of this session is to demonstrate and impress upon you the importance of proper and correct charting of your residents in the care home setting. This is a requirement of your daily work with the 4 to 5 residents in your homes.	2 min.	
B. It is important and necessary to chart your observations and behavior of your residents for the following reasons:		The reasons for charting to be written on the blackboard and kept on throughout lecture. (This is to be done before class session begins to expedite process in innumeration. This is also to provide learning reinforcement.)
1. Indicates to the licensing agency the quality of your care and interactions with your clients.		
2. Provides the physicians, social workers and other health professionals information about your client's behaviors (normal and abnormal).		
3. Provides licensing evaluators a yearly review for relicensing.		
4. Protects your care home from legal jeopardy should your records be subpoenaed.		
Ask students: Any questions? If not, ask students, "who would like to tell me one reason why charting is important?" Acknowledge and call student by name.	1 min.	
Currently, there are approximately 16 cases of care homes being investigated for questionable abuse and neglect of clients. Failure to chart about your observations on your clients is neglect.		Give a case study. A Care Home Administrator (CHA) was unable to convince her resident to take his medications. She informed the Social Worker and called the physician about the behavior. The CHA could not get the resident to visit the doctor. Consequently, the client became more

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		despondent and jumped from a bridge. Family of the deceased charged the CHA with neglect. Since there were no current charting indicating a call to physician and social worker, she is now being investigated.
(Again, go over the 4 reasons why charting is important.)		
C. Objectives		
At the end of this 50-minute session, you will be able to:	1 min.	FC #1 Objectives
1. List reasons why charting is important in your care home functions.		HO #1 Objectives
2. Describe Problem Oriented Recording System (POR).		
3. List and explain the acronym of "SOAP."		
4. Demonstrate charting technique, given a situation.		After going over the objectives, tear off FC #1 and rehang on blackboard using tape. This is so students can refer to it periodically.
D. Procedure		
During this class, I will illustrate how to chart on your resident's records using the SOAP format.	1/2 min.	
Following this, I will give you a situation and ask you to chart your observations using the SOAP format and share this with the class.		

HANDOUT #1

OBJECTIVES

At the end of this 50-minute session, you will be able to:

1. List reasons why charting is important in the function of your care home.
2. Describe PROBLEM ORIENTED RECORDING (POR).
3. List and explain the acronym of "SOAP".
4. Demonstrate charting technique, given a situation.

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II. EXPLANATION		
Fifty (50) percent of your care home function as an Adult Residential Care Home (ARCH) Administrator is charting. You record the observations and care of your 4-5 residents.	1/2 min.	
1. Charting (Clients Written Records)	2 min.	
The Department of Health has a form which they suggest you use for charting. (Hold up form for class to see and handout copies.) If you run out, you may duplicate this copy.		HO #2 Copies of Progress Notes for Charting Exercise
For charting, we will use the Problem Oriented Recording (POR) system. (Go to the blackboard and write: POR = P O R) r r e o i c b e o l n r e t d m e i d n g		
Charting is a written record of your observations and care of your residents. Example is any written notation on the designated form informing other caregivers about residents.		
This POR is a general term used in charting. The purpose for using this system is to focus on client care--not on medical or nursing care.	2 min.	

Handout #2

PROGRESS NOTES

Name of Home_____

Patient/Resident:

Family Name First Name Physician or Clinic:

Date Time	Notes	Signature

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It provides a method of communication what, when and how things are to be done to meet your client's needs. It improves communication among all those caring for the client. The recording in the client's progress notes is done using the SOAP format. SOAP is under the POR system. (Review SOAP charting with class.) S - (subjective) What client tells you. O - (objective) What is observed and/or measureable. A - (assessment) The analysis of client's problems. P - (plan) What to do to resolve the problems. Ask students: Any questions? If not, let us look at several examples of SOAP charting. Keep in mind that the Problem Oriented Recording system focuses on the client's care--not on nursing care. Examples of SOAP Charting Example #1: Diabetic Client Date/Time Progress Notes Signature 11/6/86 1:00 p.m. S: "I feel weak and nauseated." O: Poor appetite at lunch. Perspiration on forehead and face. Hands shaking. Pulse 94/min. Denies dizziness or stomach pain A: Possible insulin reaction. P: Get uring sample and test for sugar now. Give glass of orange juice. Call Dr. Wong to inform of urine test and observations. Obtain orders for further action. Watch client closely and chart observations. Sign: T. Basuel, CHA	35 min.	FC #2 SOAP (Blank form before acronyms) FC #3 SOAP with acronyms (Explanations) FC #4 Diabetic Client Charting Example

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OUTLINE OF INSTRUCTION	TIME	METHODS OF INSTRUCTION AND AIDS
Example #2: Psychiatric Disorder Client Date/Time Progress Notes Signature 11/6/86 2:00 p.m. S: None O: Client observed to be crying silently. Tear stained face and pillow; facing the wall lying in bed. Eyes swollen. Verbalizes no discomfort or pain. Shrugs shoulders when asked questions. Non-communicative. Observed to be in this state for 20 minutes. Skin, cool and moist. A: Possible coping difficulties. P: Remain with client in room. Try to engage in conversation. Reassure. Sign: _____ For correction on errors on your charting, cross out the word(s) by drawing a line. (Demonstrate on flip chart.) Write in the correct entry and initial. (Demonstrate on flip chart.) Suppose you've observed that the client and the problem persists after carrying out your plan? Let us continue with our charting on this particular client and turn to the next phase of the observation.		FC #5 Psychiatric Disorder Client Charting Example

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Example #3: Psychiatric Disorder Client Date/Time — Progress Notes — Signature 11/6/86 2:30 p.m. S: None O: Remains in same position as at 2 p.m. Crying continues. Refused snacks offer at 2:15. Thorazine medication refused as prescribed now. A: Ineffective coping. P: Call Dr. James to inform. Obtain orders. Continue to keep client within hearing and visual range. Continue to reassure and offer Thorazine. Sign: _____ You then proceed to carry out your plan and call the doctor. After speaking with the physician, chart the orders.		FC #6 Psychiatric Disorder Client Continuation of charting example. 2:30 p.m.
Example #4: Psychiatric Disorder Client Date/Time — Progress Notes — Signature 11/6/86 2:40 p.m. Telephone call to Dr. James. Doctor ordered: 1) Encourage to take meds. 25mg Thorazine now. 2) Continue to monitor. 3) Bring client to office if unable to give meds in the next hour. Sign: _____		FC #7 Psychiatric Disorder Client Continuation of charting example. 2:40 p.m.

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OUTLINE OF INSTRUCTION	TIME	METHODS OF INSTRUCTION AND AIDS
Example #5: Psychiatric Disorder Client Date/Time Progress Notes 11/6/86 4:00 p.m. S: None O: Crying continues. Observed to shift position one time. Fetal position observed. Refused prescribed Thorazine medication 25mg as ordered. A: Ineffective coping. P: Take to Dr. James' office now. Elicit assistance of family to transport. Sign: _____		FC #8 Psychiatric Disorder Client Continuation of charting example. 4:00 p.m.
Let us do a charting exercise together. I have a picture on an overhead. Look at it closely and on this flip chart (have a FC prepared to resemble a charting form with SOAP written on it) come up and write your entry so that we can all work on it together. Refer to the SOAP acronym as a guide if you wish.		HO #2 Charting Form
Here is the background of this picture on the overhead. The time is 12 noon; client is eating BREAKFAST brought in by family members who are visiting. Client is a diabetic. How would you chart your observations?		OH #1 Picture of client sitting at the table at 12 noon for BREAKFAST
Ask students: Any questions?		

OVERHEAD #1

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Example of completed charting of FC #12 Date/Time — Progress Notes — Signature 11/6/86 12 noon S: None or "This is delicious." O: Sitting at breakfast at 12 noon. Breakfast brought in by family members who are in living room visiting. Breakfast consists of 2 eggs (fried), 3 strips of bacon, bread and fresh apples. Appears happy. A: Potential for insulin reaction related to late breakfast and content. Lack of understanding and adherence to diet. P: Request to have family and client consult with a nutritionist to discuss appropriate diet. Suggest a diabetic diet instead. Watch for insulin reaction due to diet non-adherence. Inform physician of client's diet intake. Consult with S.W. re dietary problem. Sign: _____ 2. Quiz Written questions: a. List at least 2 out of the 4 reasons given why charting on your residents is necessary. Answer: 1) Indicates to the licensing agency the quality of your care and interactions with your clients. 2) Provides the physicians, social workers and other health professionals information about your client's behaviors (normal and abnormal).		FC #9 SOAP Blank spaces. To be filled out by class. FC #10 Completed form

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3) Provides licensing evaluators a yearly review for relicensing. 4) Protects your care home from legal jeopardy should your records be subpoenaed. b. What is the definition of charting as it applies to your care home? Give an example of charting. Answer: Charting is a written record of your observations and care of the resident. An example in a care home would be when I write on a record form regarding my resident to inform other health professionals of my resident's needs and care given. c. Describe POR. Answer: Problem oriented recording system. It focuses on resident's problems, not medical or nursing. d. List and explain the acronym of "SOAP." Answer: S - subjective - what client says O - objective - what is observed and measured A - assessment - analysis of client's problems P - plan - what to do about it		

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III. SUMMARY		
We have discussed how charting is important to the operation of your care home. We have gone through SOAP charting exercises to use as a guide in your recording and charting.	2 min.	
At this time, I again remind you about the legal considerations in charting. It is important to remember that "legal" action may be taken against a person who falsifies a patient's chart. Information of this sort includes: (1) concealing real nature of an operation; (2) deceiving insurance companies /or governmental agencies doing placement of residents in your home/; (3) concealing information to protect a doctor or hospital from consequences of a mistake.		
(Source: Wood, Lucille and Rambo, Beverly. Nursing Skills for Allied Health Services. Philadelphia, PA. W.B. Saunders Co., 1977.		
From a legal standpoint, charting is one of the most significant duties that the health workers performs. It is a written picture of the resident(s). Because I am discussing legal actions and responsibilities, you need to be aware of your client's rights to privacy. Discussion of your clients with others who are not involved in their care is wrong. The charts on your clients belong to your home and you have a responsibility to enforce confidentiality of your records. These should only be reviewed by those designated. Your care home policy and procedures should state this.		
Ask students: Any questions? If not, can someone tell me what kind of information is considered falsifying a patient's chart?	4 min.	Question and answer period.

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Answer: 1) Concealing real nature of an operation. 2) Deceiving insurance companies (or governmental agencies doing placement of residents in your home.) 3) Concealing information to protect a doctor or hospital from consequences of a mistake.		

FLIP CHART #1

OBJECTIVES

At the end of this 50-minute session, you will be able to:

1. List reasons why charting is important in the function of your care home.
2. Describe PROBLEM ORIENTED RECORDING (POR).
3. List and explain the acronym of "SOAP".
4. Demonstrate charting technique, given a situation.

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SOAP CHART BLANK FORM

Flip Chart #2

S:

O:

A:

P:

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SOAP CHART COMPLETE FOR ACRONYM FLIP CHART # 3

S: (Subjective) What client tells you.

Example: "I feel junk."

O: (Objective) What is observed and/or measureable.

Example: Dark orange urine, approximately 60 ccs. Sticky texture.

A: (Assessment) The analysis of client's problem.

Example: Possible bladder or urinary infection.

P: (Plan) What to do to resolve proble.

Example: Call the doctor's office for appointment.

Get further instructions from doctor.

Watch for change in client and record every 15-30 min.

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Charting Example #1 Diabetic Client Flip Chart # 4

Date/Time	Progress Notes	Signature
11/6/86 1:00PM	S: "I feel weak and nauseated". O: Poor appetite at lunch. Perspiration on forehead and face. Hands shaking. Pulse 94/min. Denies dizziness or stomach discomfort. A: Possible Insulin reaction. P: Get urine sample and test for sugar now. Give glass of orange juice now. Call Dr. Wong to inform of urine test and observations. Obtain orders for further care. Watch closely and chart observations.	

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Charting Example #2 Psychiatric Disorder Client Flip Chart #5

PROGRESS NOTES

Name of Home:
Patient/Resident
Family Name_____ First_____ Physician or Clinic_____

Date/Time	Notes	Signature
11/6/86 2:00PM	S: None O: Client observed to be crying silently. Tear strained face and pillow; facing the wall lying in bed. Eyes swollen. Verbalizes no discomfort or pain. Shrugs shoulders when asked questions. Non-communicative. Observed to be in this state for 20 min. Skin, cool and moist. A: Possible coping difficulties. P: Remain with client in room. Try to engage in conversation. Reassure.	_____

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Charting Example #3 Psychiatric Disorder Client Flip Chart # 6

PROGRESS NOTES

Name of Home:
Patient/Resident
Family Name_____ First_____ Physician or Clinic_____

Date/Time	Notes	Signature
11/6/86 2:30PM	S: None. O: Remains in same position as at 2PM. Crying continues. Refused snacks offered at 2:15. Thorazine medication refused as prescribed now. A: Ineffective coping. P: Call Dr. James to inform. Obtain orders. Continue to keep client within hearing and visual range. Continue to reassure and offer medication as prescribed.	_____

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Charting Example #4 Psychiatric Disorder Client Flip Chart # 7

PROGRESS NOTES

Name of Home:
Patient/Resident
Family Name_____ First_____ Physician or Clinic_____

Date/Time	Notes	Signature
11/6/86 2:40PM	Telephone Dr. James. Dr. ordered: 1) Encourage to take meds. 25 mg. Thorazine now. 2) Continue to monitor. 3) Bring client to clinic if unable to give medications in next 1-2 hours.	_____

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Charting Example # 5 Psychiatric Disorder Client Flip Chart #8

PROGRESS NOTES

Name of Home:
Patient/Resident
Family Name_____ First_____ Physician or Clinic_____

Date/Time	Notes	Signature
11/6/86 4:00PM	S: None. O: Crying continues. Observed to shift position one time. Fetal position pronounced. Refused prescribed Thorazine medication. A: Ineffective coping. P: Take to Dr. James Office as ordered. Elicit family's assistance to transport.	_____

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Flip Chart #9 Blank form

Date/Time	Progress Notes	Signature
	S: O: A: P:	

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Flip Chart # 10 Complete

Date/Time	Progress Notes	Signature
11/6/86 12 Noon	S: None. O: Sitting at breakfast 12N. Breakfast brought in by family members who are in living room visiting. Breakfast consists of 2 eggs, fried; 3 strips of bacon, bread and fresh apples. Appears happy. A: Potential for Insulin reaction related to breakfast hour and content. Possible lack of understanding and adherence to diet. P: Request to have family and client consult with nutritionist to discuss appropriate diet. Suggest a diabetic diet instead. Watch for Insulin reaction due to poor diet adherence. Inform physician of client's diet intake. Inform social worker of diet adherence and management difficulty.	
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